

STATE OF NEBRASKA

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DATE OF ISSUANCE

JUN 19 2012

LINCOLN, NEBRASKA

Stanley S. Cooper
 STANLEY S. COOPER
 ASSISTANT STATE REGISTRAR
 DEPARTMENT OF HEALTH AND
 HUMAN SERVICES

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

1 PLACE OF DEATH

County _____ State _____ Registered **3380**
 Township _____ or Village _____ or
 City Oesha No. Wise Map St., _____ Ward _____
(if death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ignaty Neuman

(a) Residence. No. 5120 13 St., 4 Ward. 143
(Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married

5a If married, widowed, or divorced HUSBAND of _____

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE Years 62 Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Business
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9 BIRTHPLACE (city or town) (State or country) Austria

10 NAME OF FATHER Neuman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Ella

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Sam Neuman (Address) city

15 Filed Private REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1920, to Apr. 29, 1921, that I last saw him alive on Apr 29, 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
88A
 (duration) 12 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. mos. ds.

18 Where was disease contracted _____ If not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) J. J. Hensley, M. D.
 _____, 19 _____ (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Presque Isle DATE OF BURIAL 7/30 1921

20 UNDERTAKER Shackelton ADDRESS _____